Source: Zia Partners

Assuring a System of Care Designed to Serve Individuals and Families with Multi-occurring Conditions and Disabilities, and other Complex Needs

A Guide for Universal Implementation

Definitions:

Multi-occurring conditions: An individual with multi-occurring conditions is defined as any person of any age with ANY combination of any MH condition (including trauma) and/or developmental or cognitive disability (including Brain Injury) and/or any Substance abuse condition, including gambling and nicotine dependence, whether or not they have already been diagnosed. Individuals with multi-occurring conditions commonly also have medical, legal, housing, financial, and parenting issues and conditions and other complex needs.

Multi-occurring family: A family where one person has an issue or condition in one area, like a child with a developmental disability and/or a serious emotional disturbance, and another member has an issue in another area, like a parent or caregiver with a substance abuse condition, so that the family system needs an integrated approach.

Prevalence of multi-occurring conditions: The prevalence of individuals and families with multi-occurring conditions and disabilities is sufficiently great in all settings serving people with disabilities that "multi-occurring" should be regarded as an expectation, not an exception in all populations receiving service in the Iowa public delivery system.

Recommended position statement for the workgroups:

For individuals and families seeking services in Iowa, multi-occurring issues should be the expectation, not the exception. We need to design a system in the State in which all services are organized to welcome, inspire and provide integrated services to individuals and families with multi-occurring conditions and disabilities, and other complex needs. Therefore, we recommend that as part of addressing the elements of each workgroup's charge (e.g. eligibility, core services, workforce, accreditation, performance measurement/quality management), Iowans should expect all agencies and programs in the State that provide mental health, intellectual/developmental disabilities, brain injury and substance abuse services to commit to work as partners, both statewide and in regional systems, to develop "multi-occurring capability" within their existing resources and according to their stated missions, by continuously improving their ability to address the needs of individuals and families with multi-occurring issues and disabilities.

There is an existing partnership and a structured process within Iowa that has been working toward this goal since 2009, which includes a team of "change agents," the Iowa Co-occurring Recovery Network (ICORN), who have been making progress in the development of an integrated system, using a framework called the Comprehensive Continuous Integrated System of Care (CCISC). (Minkoff & Cline: 2004, 2005). Progress has been made both by individual agencies and programs, as well as in local systems of care convened by CPCs (Linn County, and Webster County for example). We recommend that all providers and local/regional systems join in this process as partners to build on the existing successes of ICORN toward creating a statewide system in which integrated services are a universal expectation and every door is the right door for people with multi-occurring issues and complex needs.

More Definitions:

Multi-occurring (or co-occurring) capability: For any type of program, within the mission and resources of that program, person-centered (also termed: recovery-oriented or resiliency-oriented) multi-occurring capability involves designing every aspect of that program at every level on the assumption that the next person "coming to the door" of the program is likely to have multi-occurring issues and needs, and they need to be welcomed for care, engaged with empathy and hope, and provided what they need in a person-specific and integrated fashion in order to make progress toward having a happy productive life. Multi-occurring capability necessitates that all care is welcoming and person-centered. This dynamic approach to service and care is attuned to people and families with diverse goals, strengths, histories and cultures. Multi-occurring capability involves looking at **all** aspects of program design and functioning in order to embed integrated policies, procedures and practices in the operations of the program to make it easier and more routine for each person delivering care or supports to deliver integrated care successfully.

CCISC: CCISC (Comprehensive Continuous Integrated System of Care) (Minkoff and Cline, 2004[1], 2005[2]) is both a framework and a process for designing a whole system of care to be about the complex needs of the individuals and families being served. In CCISC, all programs in the system engage in partnership with other programs, along with the leadership of the system, and consumer and family stakeholders, to become welcoming, person-centered (also, as appropriate, recovery-oriented or resiliency-oriented), and multi-occurring capable. In addition, every person delivering and supporting care is engaged in a process to become welcoming, person-centered, and multi-occurring competent as well.

Implementation of CCISC in real-world systems with limited resources is based on significant advances in clinical knowledge in the last two decades. We now have enough knowledge to know how to successfully embed practices in any program in

order to be helpful to individuals and families with complex multi-occurring needs. Such practices are organized by Eight Core CCISC Principles, and placed in an integrated philosophical framework to create a common language throughout the whole system. Such practices involve welcoming access, integrated screening and assessment, empathic hopeful integrated relationships, stage matched interventions, strength-based skill-based learning, and using positive contingencies to reward progress a day at a time. CCISC implementation helps all programs in the system, through the use of COMPASS and other tools, to learn how to apply the CCISC principles to build multi-occurring capability into all areas of practice and programming in their own programs, and to work in partnership with other programs in their local/regional system to help those programs make progress, and to share responsibility for a common population of people with complex needs.

Recommendations for Implementation

In addition to the general position statement above, successful implementation of a multi-occurring capable system for all Iowans can be supported by targeted recommendations to the legislature by each workgroup. It is important not to "over-legislate" too many specific details, or it will interfere with the flexibility necessary to design the whole system, at the state level, regional level, local level, and provider level, to be responsive to individuals and families with multi-occurring needs within available resources.

The following recommendations would be a priority:

- **State level implementation structure:** It will be extremely important to create an overarching structure at the state level to manage the ongoing implementation of a person and family centered integrated system of care within a continuous quality improvement framework. The structure should be convened under the leadership of DHS and include representation from all other key partners, including DPH, DOC, IME, regional and local intermediaries, consumer/family advocacy, provider agency representation, front line change agent representation (I-CORN), and so on. Each "partner" is responsible for implementation of multi-occurring capability within its own domain, and coming together as partners to design continuing infrastructure to support progress at all levels. This core group of system design stakeholders functions as an "implementation and oversight steering committee" to flesh out ongoing details in a "top-down, bottom up" representative partnership that remains in place over time.
- **Regional implementation:** The regional intermediaries need to be given the mandate and authority to design person-centered, integrated, regional systems of care using the CCISC framework. The development of the capability and

infrastructure of the regional intermediaries for this purpose will need to be developed over time in partnership with the State implementation structure described above. Financial incentives for quality performance can be tied to this development as well. Each region should also have a specific requirement to be accountable to local consumer/family representation on its Board, and to convene its own "implementation and oversight structure" representing diverse communities, provider types, front line service providers, and advocates within its region.

- **Eligibility: In an integrated system design process, key components of eligibility guidelines include:**
  - Individuals and families with multi-occurring issues are welcomed for service in each domain
  - Individuals and families who have poor outcomes and high costs due to multi-occurring issues are a service priority for regional systems, even if they may not meet individual eligibility requirements in any single service domain
  - Subsystems and programs serving any disability group are "priority clients" of subsystems and programs serving other groups, and prioritized for consultation, education, in-reach and support to help individuals with multi-occurring needs be more successful in any single service setting. For example, SUD or DD/BI settings are "priority clients" for access to MH consultation; MH settings are "priority clients" for access to SUD, DD, or BI consultation, etc**.**
- **Accreditation:** Accreditation guidelines should indicate that all programs subject to accreditation should be quality improvement partners within the larger process of system design, and organize measurable improvement activities to better serve individuals and families who are system priorities. In particular, each program should have an organized improvement process to attain multi-occurring capability, with specific measurable targets of progress.
- **Core Services:** Core service definitions should include the understanding that ALL service modalities and programs are designed to be multi-occurring capable within whatever resources are available to support them, in whatever service setting provides them. In addition, the core service array MUST provide flexibility to regional and local systems to develop both urgent/emergent and routine person or family-centered integrated engagement and wraparound services to help those with the greatest complexity, who may not easily fit into "conventional" service boxes, to make successful progress in the community to achieve their goals.
- **Workforce Development:** All persons (with or without credentials and licensure) delivering care and support are expected to become welcoming,

person/family-centered, hopeful/strength based, and multi-occurring competent. This is not developed by requiring “special credentials” or “mandated trainings”. Workforce development activities are a component of each program’s own multi-occurring capability improvement plan, and are reinforced through continuous learning, supervision, and the improved partnerships.

- **Performance Measurement/Quality Management:** Without defining specific tools, there should be a recommendation that state, regional, and provider performance measurement and quality management parameters are connected to the system wide quality improvement process of developing universal multi-occurring capability. Data elements and indicators that provide good starting places include: Collecting routine clinical and management data on the prevalence of multi-occurring conditions in EACH data system; measurement of welcoming, access, and retention for individuals and families with multi-occurring needs in each program, community, and region; tracking development of a state and regional performance improvement process that supports universal multi-occurring capability; and tracking concrete progress of each program in its own multi-occurring capability improvement activities. **Tertiary outcomes of developing system wide multi-occurring capability relate to the following: improvement in receiving integrated care to make progress in rehabilitation and recovery outcomes on multiple issues, including improved health status, AND reduction in acute inpatient care, residential placement, incarceration, and housing instability, for individuals with multi-occurring issues, all within existing resources.**